Hello,

This email is to confirm your sleep study scheduled for _____. Arrival time for the study is between 9:00-9:30pm.

Please complete the Patient Packet and bring it with you when you come for your sleep study.

Reminder: Address 6080 N. Central Expressway Dallas, TX 75206.

FYI… We are located behind the Beeman Hotel. Please park in the parking garage on the blue level for Neuro Patients near the north elevator. When you arrive, please call (214)443-5154 to let your technologist know that you have arrived and the technologist will meet you at the entrance on the first floor.

Number to call upon arrival: (214)443-5154

Please reply that you have received this email.

<u>PLEASE BE AWARE THAT FAMILY, SIGNIFICANT OTHERS, CHILDREN AND/OR PETS ARE NOT ALLOWED**</u> If you feel that you need to bring someone with you to the Sleep Center, please call 214-827-3610 ext. 236 prior to the night of you sleep study.**

In case of COVID-19, flu-like symptoms or recent hospitalizations/ER visits, please contact us ASAP so that we can assess the situation and reschedule your appointment if necessary. Call 214-827-3610 ext. 236 prior to the night of you sleep study. If you are not able to call before 5:00 pm Monday – Thursday or noon on Friday on the night of your sleep study, please call 214-443-5154 after 8:30 pm. For those with Saturday appointments, please call 214-443-5154 after 8:30 pm.

Thank you,

Annette Ferrell, RPSGT CCSH

Texas Neurology
6080 N. Central Expressway, Suite 100
Dallas, TX 75206

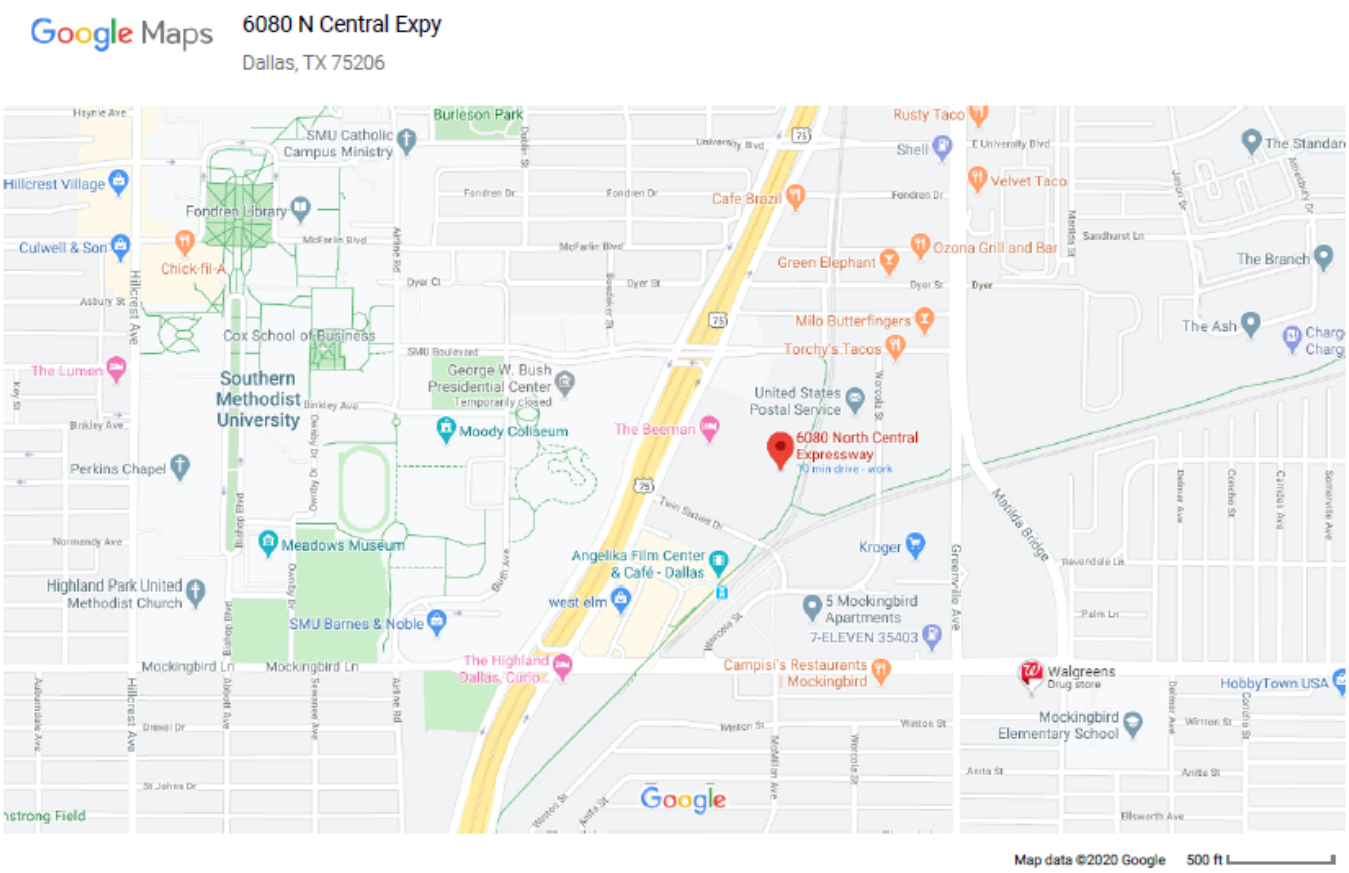
On the night of your study:

1. If you have any symptoms of the COVID-19 virus, have been exposed or have been around anyone who has been exposed, please call to reschedule your appointment. Please see separate sheet listing symptoms.
2. Please bring your pillow and blanket, night attire to change into as well as any toiletries, medication(s), and any other items you may require. Take your medications as prescribed unless your physician advised you not to. If you are taking medications to help you sleep, please talk with your tech about when to take it.
3. In order to ensure proper electrode and sensor application, please arrive freshly showered with your hair washed and completely dry. Do not use any body lotion, make-up, hair spray or gels. You may wear under-arm deodorant. Men are required to shave prior to the study. However, beards are acceptable.
4. Please feel free to bring reading material. A lounge is available for your use prior to your sleep study.
5. If you are suffering from severe sinus or cold symptoms prior to your appointment, please contact the Sleep Disorders Center prior to your scheduled arrival time at 214-827-3610 ext. 236 or if after 5:00 pm, call 214-827-3610 ext. 218. You may need to reschedule.
6. Do not take naps on the day of your scheduled sleep study and avoid caffeine and alcohol after lunch.
7. Electrodes will be placed on your scalp. Please notify us immediately if there is anything that may interfere with the necessary process (hair weaves, toupee, extensions, etc.).
8. The morning following your sleep study, please allow additional time for your normal routine to have all the testing equipment removed by the technologist as well as time for you to shower if you would like to.
9. If you have any additional questions prior to your sleep study, please feel free to contact us 214-827-3610 ext. 236 or at 214-827-3610 ext. 218 after 8:30 pm.

Post Study:

1. It will take approximately a week to ten days to receive the sleep study results.
2. You will be contacted by a scheduler at the main office to set up a follow-up appointment to review your sleep study results, if a follow-up appointment has not already been scheduled. Your follow-up will be scheduled with a Texas Neurology sleep specialist under the direction of the sleep director, Dr. Waleed El-Feky.
3. In some cases, a second sleep study is required if your first sleep study demonstrated conclusive results for obstructive sleep apnea. In this case, the sleep center coordinator will contact you with the results and explain the procedures for the treatment study.
4. If you have any questions, please contact the Sleep Center's Coordinator at 214-827-3610 ext. 236.

Our new location is 6080 North Central Expressway. We are so excited to see you here!
You can find more information on our website www.texasneurology.com

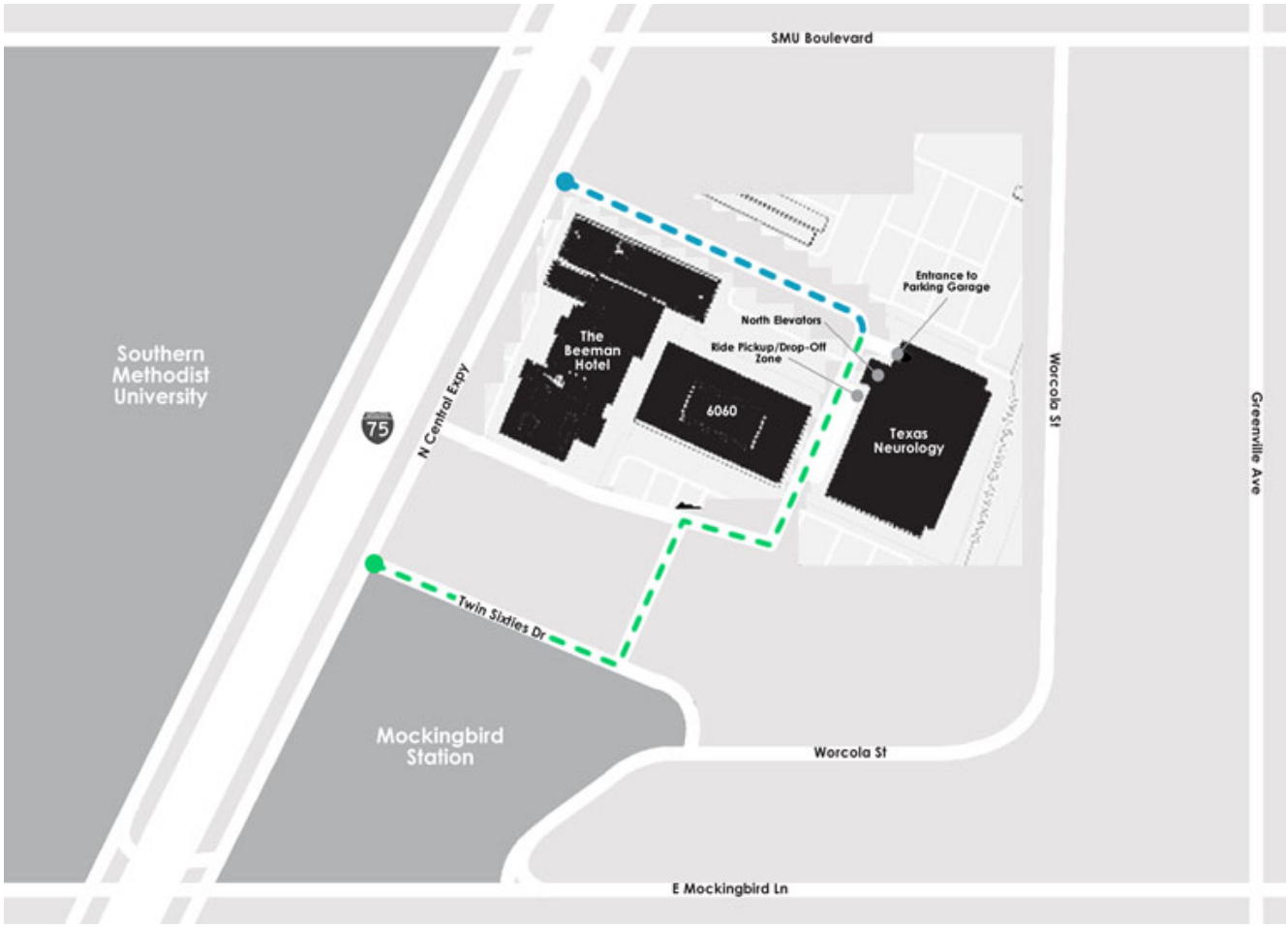


We are near Mockingbird Station between Mockingbird Lane and SMU Boulevard. The Texas Neurology building is behind the Beeman Hotel and there is a parking garage for your convenience.

Please park on the blue level marked Neuro patients near the north elevator.

Once you arrive, please call the tech to come escort you to the Sleep Center suite. The number to call is 214-443-5154.

Continue to next page to view map for entry to parking lot/garage.



This map shows two different ways to the Texas Neurology building, one turning at Twin Sixties Drive and the other has you make the first right into the parking lot immediately north of the Beeman Hotel.

TEXAS NEUROLOGY, P.A. SLEEP DISORDERS CENTER
SLEEP QUESTIONNAIRE

Last Name:_____ First Name: _____ Middle Initial:____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: ___/____/_____ Age:_____ Gender: ☐ Male ☐ Female

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native-American
☐ Other_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation:_____

Height: _____ Weight:_____ Neck Circumference in Inches:_____

Has there been any recent weight gain or loss? ☐ Loss of _____ pounds ☐ Gain of _____ pounds
Explain:_____

Over how many months has this weight gain or loss occurred? _____

Have you had a Home Sleep Test before? ☐ Yes ☐ No
If yes, please document - Date: _____ Location: _____

WELCOME TO OUR SLEEP CLINIC! The following questions will help us understand more about you. These questions will also help the physician when he looks at your sleep study. Please ask your bed partner to help you answer these questions. Please answer the questions as accurately as possible as they relate to the last 12 months. Do not leave any question unanswered. You may add comments to any of your answers in the margin beside the question. **ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.**

Answer the questions using our number scale, if your answer is "no", please circle "no".
1=rarely or never 2=sometimes 3=often 4=frequently 5=always

1. Your main complaint(s) is: ☐ Snoring ☐ My breathing stops ☐ I'm sleepy ☐ I can't fall asleep
☐ I talk or walk in my sleep ☐ Other:_____

2. How long have you had this problem? _____years _____months

3. How has this problem affected your life? _____

4. Do you feel that you get enough sleep at night?	No	1	2	3	4	5
5. Do you feel that you get too much sleep at night?	No	1	2	3	4	5
6. On average how many hours do you sleep in a 24-hour period? _____hrs						
7. What time do you go to bed at night? _____						
8. What time do you wake up in the morning? _____						
9. Do you vary this pattern on weekends?	No	1	2	3	4	5
10. No matter how much sleep you get, do you wake up feeling tired?	No	1	2	3	4	5
11. Do you have a problem with your work performance because you are sleepy or tired?	No	1	2	3	4	5
12. Have you fallen asleep at work?	No	1	2	3	4	5
13. Have you fallen asleep while driving?	No	1	2	3	4	5
14. Do you sleep with a bed partner?	No	1	2	3	4	5
15. Do you snore?	No	1	2	3	4	5
16. Does your snoring disturb others?	No	1	2	3	4	5
17. Do you hold your breath or gasp for air in your sleep?	No	1	2	3	4	5
18. Do you have trouble breathing at night?	No	1	2	3	4	5
19. Is your sleep is disturbed by tossing and turning at night?	No	1	2	3	4	5
20. Do you sweat excessively during the night?	No	1	2	3	4	5
21. I wake up in the morning with a headache.	No	1	2	3	4	5
22. I have asthma attacks during sleep.	No	1	2	3	4	5
23. My legs seem to kick constantly during sleep.	No	1	2	3	4	5
24. There are times when I must fall asleep and cannot stop it.	No	1	2	3	4	5
25. I have felt muscle weakness when I have strong emotional feelings.	No	1	2	3	4	5
26. I have vivid dreams right after I fall asleep.	No	1	2	3	4	5

27. I am unable to move when I wake up. No 1 2 3 4 5

28. A nap does not make me feel refreshed. No 1 2 3 4 5

29. Do you purposely nap on weekends? No 1 2 3 4 5

30. How often do you nap and how long do you nap? _____

31. What time do you nap? _____am _____pm

32. I have a problem falling asleep at night. No 1 2 3 4 5

33. How long does it take you to fall asleep? _____minutes

34. I require special conditions to fall asleep at night. (i.e.; music, tv) No 1 2 3 4 5

35. As I try to fall asleep, I have anxious thoughts race through my head. No 1 2 3 4 5

36. I awaken with anxiousness, dread, or worry. No 1 2 3 4 5

37. On average, how many times do you wake up during the night? _____

38. How long do you spend awake during the night?_____

39. On average, how many times do you wake during the night?_____

40. How long do you spend awake during the night?_____

41. Is your sleep disturbed by a medical problem? ☐ yes ☐ no If yes, please list: _____

_____

42. I awaken because of aches, pains, and headaches. No 1 2 3 4 5

43. As a child, did you have a problem falling asleep or waking up in the morning? No 1 2 3 4 5

44. Do you have trouble going back to sleep if you wake during the night? No 1 2 3 4 5

45. I am bothered by outside noises during the night such as planes, trains, or barking dogs. No 1 2 3 4 5

46. I tend to fall asleep when trying not to, or in a place other than my bedroom. No 1 2 3 4 5

47. As bedtime approaches, I become anxious. No 1 2 3 4 5

48. When I am awake at night I will lie there until I fall back asleep.	No	1	2	3	4	5
49. Because of my poor sleep at night I feel fatigued or "washed out" during the day.	No	1	2	3	4	5
50. I have a crawling, creeping, feeling in the back of my legs which keeps me from falling asleep.	No	1	2	3	4	5
51. Do you now or did you as a child do some sort of body rocking or head movements during sleep?	No	1	2	3	4	5
52. Do you now or did you as a child awaken in a room other than the one you went to sleep in?	No	1	2	3	4	5
53. Are you now or have you ever been a sleepwalker?	No	1	2	3	4	5
54. According to your bed partner, have you ever seemed to be acting out a dream while asleep?	No	1	2	3	4	5
55. Do you now or have you ever suffered from nightmares?	No	1	2	3	4	5
56. According to your bed partner, have you ever awakened screaming in fear and acting agitated?	No	1	2	3	4	5
57. Do you now or have you ever had seizures in your sleep?	No	1	2	3	4	5
58. I wake in a state of panic or distress?	No	1	2	3	4	5
59. I talk in my sleep.	No	1	2	3	4	5
60. I grind my teeth when sleeping.	No	1	2	3	4	5
61. I feel "groggy" or "sleep drunk" when I wake in the morning.	No	1	2	3	4	5

62. Do you work a swing shift? ☐ yes ☐ no If yes, what hrs.? _____

63. If yes, does your shift rotate in a clockwise direction? ☐ yes ☐ no

64. Do you go to bed at the same time every night? ☐ yes ☐ no

65. Do you fall asleep earlier than you want to, sleep normally, then wake in the early morning hours?	No	1	2	3	4	5
66. Do you feel sleepy late at night, then receive less sleep due to a necessary early wake time?	No	1	2	3	4	5
67. Do you sleep in several small periods of time during a 24-hour period?	No	1	2	3	4	5

68. Do you have significant stress in your life at the present life at the present time? No 1 2 3 4 5

69. Do you presently feel sad or depressed? No 1 2 3 4 5

70. Have you ever been seen by a psychologist or psychiatrist? No 1 2 3 4 5

71. Do you take medications to stay awake/fall asleep? ☐ yes ☐ no

72. Do you sleep in a water bed? ☐ yes ☐ no

73. Do you eat one to two hours before sleep? ☐ yes ☐ no

74. Do you smoke before sleep? ☐ yes ☐ no

75. Do you exercise before sleep? ☐ yes ☐ no

76. Do you sleep alone? ☐ yes ☐ no

77. Do you watch TV nightly in bed? ☐ yes ☐ no

78. Have you ever had a sleep study before? ☐ yes ☐ no

79. Do you have any relatives with a sleep disorder? ☐ yes ☐ no

80. Do you use recreational drugs? ☐ yes ☐ no

81. Do you experience any pain that keeps you from sleeping? ☐ yes ☐ no

If yes, list the location: _____

Pain type: ☐ dull ☐ aching ☐ sharp ☐ Other: _____

What causes the pain? _____

What relieves the pain? _____

PLEASE LIST YOUR INTAKE OF THE FOLLOWING

Coffee	_____	per day	Liquor	_____	per day
Tea	_____	per day	Soda	_____	per day
Beer	_____	per day	Cigarettes	_____	per day
Cigars	_____	per day	Pipes	_____	per day
Snuff	_____	per day			

Please list your medications, both prescription and over the counter. You may use the back of this form if needed.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you allergic to any medications? ☐ yes ☐ no

If yes, please list the medication (s) _____

_____

_____

_____

Any other known allergies? ☐ yes ☐ no

If yes, please list_____

_____

_____

_____

_____

HEALTH HISTORY

Please check any problem(s) or illness(es) you have or have had.

☐ High blood pressure	☐ Heart disease	☐ Heart attack	☐ Diabetes	☐ Asthma
☐ Low blood pressure	☐ Fainting	☐ Dizziness	☐ Headaches	☐ Arthritis
☐ Bladder problems	☐ Black outs	☐ Epilepsy	☐ Impotence	☐ Seizures
☐ Ringing of the ears	☐ Allergies	☐ Depression	☐ Bronchitis	☐ Anxiety
☐ Mental problems	☐ Back trouble	☐ Ulcers	☐ Eye problems	☐ Cancer
☐ Hearing problems	☐ Pneumonia	☐ Hemophilia	☐ Tuberculosis	☐ Hernia
☐ Prostate trouble	☐ Muscle cramps	☐ Meningitis	☐ Kidney problems	☐ Gout
☐ Venereal disease	☐ Heartburn/reflux	☐ Other: _____		

Do you have any other past or present medical or psychiatric problems or have you had any recent surgeries?
☐ yes ☐ no

Please list: _____

_____

_____

_____

_____

_____

Have any of your family members had or currently have a sleep disorder? ☐ yes ☐ no

Please list: _____

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature **Reviewed By – Physician or Designee Signature**

ACCREDITED
MEMBER CENTER

TEXAS NEUROLOGY SLEEP DISORDERS CENTER
THE EPWORTH SLEEPINESS SCALE

NAME: _____

DATE: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling "just tired"? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation.
0=would never doze
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (movie theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking quietly to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____

I understand that I should not drive when sleepy or drowsy.

_____

Patient Signature

TEXAS NEUROLOGY SLEEP DISORDERS CENTER

CONSENT FOR POLYSOMNOGRAPHY

I understand I will be undergoing a sleep study. Electrodes and sensors will be attached to my body. The tape used may cause discomfort during removal and the tape or cream used may cause redness at the attachment site. During the study, I will be free to roll over in bed, but will have to ask for assistance to get out of bed to use the restroom. I will be observed by the technician on camera throughout the study. There are no significant risks to me during the study, and I understand the reason for the test and the procedure has been explained to me.

_____ _____

Signature (patient or guardian) **Date**

_____ _____

Signature (witness) **Date**

ACCREDITED
MEMBER CENTER

TEXAS NEUROLOGY SLEEP DISORDERS CENTER
PERMISSION TO PHOTOGRAPH AND/OR AUDIO-VIDEOTAPE

I,_____,
Patient/Guardian

hereby authorize the taking of photograph(s) and/or audio-videotape(s)

of_____.
Name of Patient

By the Texas Neurology, PA staff, with the understanding that such photograph(s) and/or videotape(s) may be used for clinical or educational purposes or in the event of legal action. Texas Neurology, PA and trustees of Texas Neurology, PA and its duly appointed representatives are hereby released without recourse from any liability arising from the taking and use of such photograph(s) and/or videotape(s). The undersigned also hereby transfers and assigns to Texas Neurology, PA the right to copy the materials in whole or in part. Any use of the tape for medical education will not identify me by name.

( ) Check here if you do NOT authorize use for educational purposes

_____ _____
Signature (patient or guardian) **Date**

_____
Relationship (if guardian)

_____ _____
Signature (witness) **Date**

TEXAS NEUROLOGY SLEEP DISORDERS CENTER
SLEEP LOG

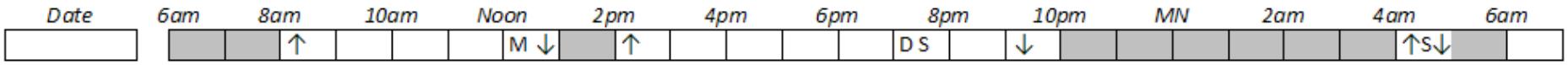
ACCREDITED MEMBER CENTER

Name:_____

INSTRUCTIONS: Complete these logs as instructed using the directions provided below. Complete the logs in the morning and the evening. Do not complete the logs during the night. Write additional comments on the back. Bring these logs with you for your appointment or mail them to your physician.

1. Leave the times you are awake BLANK.
2. SHADE, crosshatch, or color the times when you sleep.
3. ARROW DOWN whenever you lie down to sleep.
4. ARROW UPWARD when you awaken (include naps.)
5. "M" for meals, "S" for snacks, and a "D" for drinks with alcohol
6. Include notes below each week or on the back.

EXAMPLE:



FIRST WEEK

Date	6am		8am		10am		Noon		2pm		4pm		6pm		8pm		10pm		MN		2am		4am		6am	

SECOND WEEK

Date	6am		8am		10am		Noon		2pm		4pm		6pm		8pm		10pm		MN		2am		4am		6am	